BEFORE THE

STATE OF CALIFORNIA

OCCUPATIONAL SAFETY AND HEALTH

APPEALS BOARD

In the Matter of the Appeal of:

IRWIN INDUSTRIES, INC.
325 Rocklite Road
Ventura, California 93001

Employer

DOCKETS 08-R6D4-1454 through 1456

ERRATUM

A Decision of the Occupational Safety and Health Appeals Board was issued in this matter on September 25, 2008. The Summary Table is amended as follows:

ALJ upheld Citation 2 in part and dismissed in part, ***reclassifying the citation to General and reducing the penalty***. *(Please see the attached Decision and Amended Summary Table)*

The Amendment relates back to the date of issuance of the Decision and is effective as of that date.

Ursula L. Clemons

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Presiding Administrative Law Judge

DATED: July 7, 2011

ULC:ao

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In the Matter of the Appeal of: **IRWIN INDUSTRIES, INC.** 325 Rocklite Road Ventura, California 93001 Employer	**DOCKETS 08-R6D4-1454 through 1456** **DECISION**

Background and Jurisdictional Information

Irwin Industries, Inc. (Employer) is a service provider in the oil and gas industry. On February 11, 2008, the Division of Occupational Safety and Health (the Division), conducted an accident investigation at a place of employment maintained by Employer at Exxon Mobil Hill Property (18271 Hwy 33), Mc Kittrick, California. On March 27, 2008, the Division, through Ken Noble, Associate Safety Engineer, cited Employer for the following alleged violations of the occupational safety and health standards and orders found in Title 8, California Code of Regulations.[1]

Citation	Section	Classification	Penalty
1/1	3400(b) [failure to ensure near proximity of infirmary, clinic or hospital to workplace or ensure availability of first-aid trained personnel at worksite]	General	$560
2/1	3203(a)(7)(D) [failure to provide adequate training]	Serious	$18,000
3/1	3329(d) [failure to relieve pressure when dismantling or opening pressurized system]	Serious	$6,750

[1] Unless otherwise noted, all section references are to Title 8, California Code of Regulations.

The Employer filed a timely appeal contesting the existence of the alleged violations, the correctness of the classifications, the abatement requirements, and the reasonableness of the proposed penalties. Employer asserted various affirmative defenses as well.

The matter came on regularly for hearing on August 26, 2008, at West Covina, California before Ursula L. Clemons, Administrative Law Judge (ALJ) for the California Occupational Safety and Health Appeals Board. Robert Peterson, Esq., represented Employer. William Cregar, Staff Counsel, represented the Division. The matter was argued, and oral and documentary evidence was received on the hearing date. The matter was submitted on August 26, 2008.

Law and Motion

Employer made a standing hearsay objection. The Division agreed but with the understanding that administrative hearsay is admissible in administrative proceedings. The motion was granted.

The Division moved, without objection, to amend Citations 2 and 3, correcting the alleged violation date of February 7, 2007, to read February 7, **2008**. The motion was granted.

Docket 08-R6D4-1454

Citation 1, § 3400(b), General

Summary of Evidence

Ken Noble (Noble) testified for the Division. He is an Associate Safety Engineer for the Process Safety Management Division (PSM). His duties include compliance inspections of high hazard materials and processes (§ 5189 standards and associated Title 8 regulations). He conducts complaint and accident inspections of the oil field industry and pressure vessel inspections as well. Noble has worked for the Division for 19 years, 10 years in the Pressure Vessel Unit and 9 years with PSM. Throughout the years Noble has conducted approximately 100 PSM inspections and 20 accident investigations, four of which were specific to pressure build up. Noble is a high school graduate and has taken some college courses including training courses from the National Board of Boiler Inspectors. He has undergone training with the pressure vessel unit and general accident training provided by the Division as well.

On February 11, 2008, Noble investigated an accident that occurred on February 7, 2008 at Employer's worksite. He met with Ruben Berumen (Berumen), Field Superintendent, for the opening

conference and received permission to inspect the premises. Berumen explained that a 14" pipe was being modified by the work crew and installation of a flange was underway by tack welding when a pipe plug dislodged and injured the welder, Ryan McDonald (McDonald). The injured employee suffered a concussion (possible brain damage), broken teeth and inner mouth injuries. Noble obtained Berumen's written statement (Exhibit 2) and took pictures of the worksite as well (Exhibit 3).

Noble explained the pipes are basically used as a gathering line of waste water products (minerals going to the first stage separator vessel of the Diatomite filtration plant). Everything is transported via pipeline. Water is a natural recurring product in the production of oil and is a product of condensation from steam injection in the filtration process. The water is heated and collected up with oil production. The crew cuts the pipe for modification of the system as requested by the customer, in this instance Diatomite plant.

The flange was being welded onto the pipe [Exhibits 3-2 through 3-8]. Small pieces of metal and corrosion or mixture of scale with residual water in the line are also depicted.[2] [Exhibit 3-5]. The pipe was equipped with an atmospheric 2" vent [Exhibit 3-6] for use during the operations. It is approximately 80 feet upstream or away from the work area. Noble explained there are major pipelines along the road to the west of where the accident occurred. The 14" pipeline at issue branched off from the major pipeline, coming up underneath the road over to the Diatomite vessel. Exhibit 3-7 depicts the inflated pipe plug involved in the accident. The plug is pushed 18" into the inside of the pipe. In the picture the plug is still inflated. The plug projections visible in the picture were facing outside the pipe, toward the flange and the welder. This is the only way the plug can be inflated and it is inflated using compressed air, similar to a tire. During the operations in question, the 14" pipeline was isolated from the main piping by shut off valves depicted in Exhibit 3-8. In the picture is a black pipe running perpendicular to the pipeline behind which is the same 2" vent (pictured in Exhibit 3-6) used to vent the 14" pipeline while the work was under way.

Noble submitted documents obtained during his investigation from Employer's supervisor. They consisted of installation instructions for pneumatic plugs (Exhibit 4). The plugs are inflated with compressed air and are rented from United Rentals. Employer's accident investigation report was presented. (Exhibit 5). The manufacturer's (Lansas) specification sheet of the Multi-Size Domehead pneumatic plug was submitted as well (Exhibit 6). Noble also submitted Employer's IIPP (Exhibit 7) and its Risk Assessment Checklist (Exhibit 8).

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[2]Noble defined "scale" as mineral water residue that collects on the inside of the pipe wall from the fluids that are transmitted through it.

Exxon Mobil issued Employer a Safety Inspection Hot Work Permit (Exhibit 9) prior to the welding project to ensure the area was free of explosive gases and fluids. The permit verified that emergency procedures were in place. Noble testified that "hot work" involves work with sparking devices or a source of ignition (i.e. welding) and involves materials that are flammable as shown in the pictures taken (Exhibit 3).

Exhibit 10, the Job Safety Analysis (JSA) lists the tasks and potential hazards for the modification job. Noble testified that on the JSA Employer identified how to remediate hazards and the potential for blowouts following plug installation was addressed as well.

Employer stipulated to the Proposed Penalty Worksheet (C-10), agreeing that the Division adhered to its procedures and policies regarding the penalty calculations for all citations. (Exhibit 14)

Specifically regarding Citation 1, Noble testified that he requested current employee first aid training records (Exhibit 13) from Employer and that none were received. He also stated Superintendent Berumen told him that the CPR certificates expired in 2007. Employer's IIPP (Exhibit 7) states under the heading Job or Competency Training that "Medic First Aid/CPR Certification" is one of the training courses provided by EH&S Department personnel. Noble presented a letter (Exhibit 12) received from Employer confirming there were no first aid certified employees. Noble testified that Citation 1 was issued because not only were there no first aid training records but also because the nearest infirmary or clinic was located in the community of Lost Hills, approximately 10 – 12 miles north of the work site. Berumen told Noble the nearest clinic/medical facility is approximately a ten minute drive from Highway 33. However, Noble added that the specific worksite known as Hill Property is quite a distance from Highway 33 and accessed via private road.

On cross-examination, Noble testified that "near proximity" is not defined in the regulations but the Division's policy is that a seven minute drive time is sufficient to satisfy the safety order. He did not ask any one of the employees about their first-aid qualifications while conducting the investigation interviews because he submitted a Document Request Sheet (Exhibit 13) to Employer. On re-direct examination Noble testified that he requested the current qualifications or training records from Employer in writing regarding first-aid and did not receive any such documents.

Employer called no witnesses to testify.

Findings and Reasons for Decision

The violation was established by a preponderance of the evidence. The proposed penalty of $560 is found reasonable and is assessed.

Section 3400(b) reads, as follows:

> In the absence of an infirmary, clinic, or hospital, in near proximity to the workplace, which is used for the treatment of all injured employees, a person or persons shall be adequately trained to render first aid. Training shall be equal that of the American Red Cross or the Mining Enforcement and Safety Administration.

The Division cited Employer alleging violation of § 3328(e) for failure to have a clinic or infirmary or hospital in near proximity to the Hill Lease worksite and for not having a person at the worksite adequately trained to render first aid.

The burden is on the Division to show each element of a violation, and the applicability of the safety order, by a preponderance of the evidence. (*Cambro Manufacturing Co.*, Cal/OSHA App. 84-923, Decision After Reconsideration (Dec. 31, 1986). The safety order allows for adequately first aid trained personnel to be at the jobsite if a medical facility is not in near proximity to the worksite. Employer submitted a written memorandum to a document request made by Noble (Exhibit 12). The memorandum was written by Employer's EH&S Specialist and states "that after an investigation of training records of IRWIN Industries personnel who were at the Hill Property worksite on February 7th, 2007 (determined to be 2008 as amended without objection) no persons held a current 1st Aid/CPR training certification." Noble testified that no first aid training records were ever provided to him, thus he could not determine if anyone present at the worksite had undergone training equal that of the American Red Cross or the Mining Enforcement and Safety Administration as required by the safety order. Based on the lack of evidence submitted by Employer that any personnel present on the day of the accident was adequately trained to render first aid, the citation was appropriately issued.

Noble testified that he was told the closest medical facility was approximately a ten minute drive from the worksite. On cross-examination, Noble admitted the regulations do not define "near proximity". Under the "plain meaning rule" of statutory construction,

words used in a safety order must be given the meaning they bear in ordinary use and, if the language is clear and unambiguous, there is no need for construction. *The Home Depot,* Cal/OSHA App. 98-2236, Decision After Reconsideration (Dec. 20, 2001).

In *McDonald's,* Cal/OSHA App. 03-4116, Decision After Reconsideration (May 31, 2007) it is well settled that when a safety order does not supply a definition for a term used in a section, the Appeals Board applies the common usage or common law meaning, in the absence of evidence of a contrary meaning. (*D. Robert Schwartz dba Alameda Metal Recycling and Alameda Street Metals,* Cal/OSHA App. 96-3553, Decision After Reconsideration (Mar. 15, 2001) citing *Kenneth L. Poole, Inc.,* Cal/OSHA App. 90-278, Decision After Reconsideration (Apr. 18, 1991).) The Board has recognized that words should be given their meaning in ordinary use, and that dictionary definitions are often used for this purpose. (*The Home Depot USA, Inc.,* Cal/OSHA App. 99-690, Decision After Reconsideration (Mar. 21, 2002), footnote 2). "Near" is not specifically defined in the safety order or in the General Industrial Safety Orders (GISO) definitions section [§ 3207(a)]. "Near" (used as an adverb) is defined as "at a short distance in space or time." As an adjective, it is defined as "close in distance or time." (Webster's New World Dictionary and Thesaurus, Second Edition (2002) p. 1312.)

The word "near" must be interpreted consistent with "the California Supreme Court's directive to liberally interpret *safety orders* to promote a safe and healthful working environment" (*Broadway Sheet Metal, supra,* at pg. 3, italics added), citing to Carmona v. Division of Industrial Safety (1975) 13 Cal.3d 303, 313, and Lusardi Construction Co. v. California Occupational Safety & Health Add. Bd. (1991) 1 Cal.App.4th 639, 645. While the court in *Carmona, supra,* was referring to Labor Code § 6306 when it stated (at pg. 313) that "... the terms of the legislation are to be given a liberal interpretation for the purpose of achieving a safe working environment", the Board has applied that principle to the interpretation of language in safety orders. (See also Labor Code § 3202)

Here the only testimony about the proximity of the clinic or hospital was offered by the Division as being 10-12 miles away. Noble was told by Employer it was probably a "10 minute drive" from the highway. Employer did not dispute the distance of the nearest clinic or hospital. However, it is noted in Employer's Incident Investigation Report (Exhibit 5) that one of Employer's employees (Richard Caudillo) escorted the fire truck and ambulance to the location of the incident after having met them at the intersection of Contractors Road and Highway 33. Thus it can be inferred that the total travel time from the actual worksite where the injury occurred is longer than the approximate 10 minute drive from the highway to the nearest medical facility.

Given the dictionary definition that near is close in distance *or* time it is reasonable that although no more than 12 miles away, it is not considered near given that it could take longer than 10 minutes travel time recognizing certain unforeseen circumstances. The purpose of the safety order is to ensure that an injured employee can get medical attention in the shortest amount of time possible. Thus, if there is pile up on Highway 33 in the direction of the nearest clinic or hospital, Employer has a duty to provide a person at the worksite who is adequately trained to render first aid immediately. Here, Employer could not present proof of such person on duty at the time of the accident. The citation is affirmed.

Docket 08-R6D4-1455

Citation 2, §3203(a)(7)(D), Serious

Summary of Evidence

Noble testified that he interviewed Robert Ruano (Crane Operator) on February 19, 2008 concerning the installation of the pneumatic plug involved in the accident. Ruano told Noble that he had not received any formal training, instead he received on the job training, watching other people install the pneumatic plugs. In addition, Ruano had never installed a plug that large in diameter, he had only installed plugs measuring 2"-6" in diameter. Ruano told Noble that he never received the United Rental installation instructions. Ruano explained that he scraped down the sand or sediment with a shovel, but had not installed an external brace or block to ensure dislodging. Ruano understood that injury or death was possible if the plug was not installed correctly and dislodged.

Noble testified that the United Rental Plug Installation Instructions (Exhibit 4) directly provide that the installer must know the proper inflation pressure and back-test pressure and that blocking or bracing must be done using either wood or a metal type of device to keep the plug from moving or dislodging, if the line became pressurized causing the plug to fail. The brace or block would be visible to someone looking at the plug after it has been installed. He described the hazard the plug is designed to prevent, stating the plug is intended to isolate a pipeline from a section that is going to be worked on, such as the accident site here. The welding operation could cause the pipe to become ignited or there is a risk that the pipe could become pressurized causing the plug to become dislodged. With a slip-on flange, Noble stated the welder would have to be in front of the pipe (straight on), exposing himself while tact welding because with a slip-on flange one not only welds the outside of the pipe, but also a welding bead has to be run on the inside of the pipe.

Noble pointed out that on page 1 and 2 of the Installation Instructions (Exhibit 4) it instructs one to stay out of the danger zone, the area around a pipeline containing a plug because system failure of any kind may cause serious bodily injury.

Noble stated that given the weight of the plug and the appurtenances[3] protruding from the end of the plug, it is more likely than not that fatal serious injury or hospitalization would result from dislodging of a pneumatic plug. He testified that Ruano had experience dealing with smaller plugs only. In this instance the plug involved was 14" in diameter. On cross-examination, Noble stated he did not ask Ruano whether or not the installation process was different for larger plugs. Ruano told Noble that neither a block or brace was put in during the installation process nor was the cleaning performed down to the metal of the inside of the pipe; he only scraped the inside of the pipe where the plug was to be installed.

Both the injured employee and Ruano signed the Job Safety Analysis (JSA) forms (Exhibit 10). The employees who signed the JSA went over various hazards prior to beginning the job on February 7, 2008. Ruano testified he did not ask any questions during the meeting conducted on the morning of the accident regarding the JSA. Noble stated the 14" plug is slipped in and inflated using a valve and air hose. Ruano had installed the plug approximately 45 minutes prior to the accident.

Noble reviewed the Hot Work Permit documentation completed by Exxon as part of the pre-work inspection. The atmospheric pressure is measured by Exxon personnel to ensure there are no flammables in the area around the plug where the welding work is to be conducted. On cross-examination, Noble testified that he did not ask whether the inspector pulled or tugged on the plug before signing off on the hot work permit.

Exhibit 3-2 depicts the flange still connected to the pipe when Noble conducted the accident investigation. In Exhibit 3-8 the pipeline depicted extends 80 feet out from where the welder was working. Using Exhibit 3-8, Noble pointed to the "slip blind" flange[4] located at the upstream end of the 14" pipe. Sometime prior to the accident, the slip blind was installed at the point when the pipeline to be worked on was isolated, Employer had conducted lock-out/tag-out of the isolation valve prior to cutting the pipeline. Noble checked the mechanical integrity of

[3] Defined in the American Heritage College Dictionary (Fourth Edition) as "something added to a more important thing; an appendage". Noble was speaking of the base plate with the rings and bolts attached thereto which extend out or protrude from the end of the pneumatic plug.

[4] A "slip blind" is put on when the pipeline is isolated prior to cutting the line with the purpose of locking it out.

the flange and determined it was good. He was told that the line had been flushed with water after it was isolated, prior to the welding operation. The accident was investigated by both Exxon and Employer however it was never determined what caused the pipe plug to fail. The source of pressure is still unknown.

The Division called Robert Ruano (Ruano), to testify. Ruano had worked for Employer approximately seven months at the time of the accident. He wiped the inside of the pipe with a rag and scraped out the sand using a shovel prior to installing and inflating the plug on the day of the accident. He checked its pressure and pulled or tugged on it prior to the welder coming over to weld the flange. Ruano testified that he received hands-on training, observing others (including Nathan Romero, Foreman) install plugs. Prior to the accident he had installed between ten and fourteen plugs, although all of them were smaller than the 14" plug at issue here.

When asked whether he was familiar with the plug installation instructions (Exhibit 4), Ruano stated the documents looked familiar, as the ones attached to the plugs he installed in the past. He could not state with certainty that he had read the instructions attached specifically to this 14" plug, but he believes all plugs are installed the same way and he has read instructions in the past when he installed the smaller plugs. During his on the job training, no one ever instructed him on how to use a brace or a block. He never used a brace or block of any type to install a plug. He has never observed any other employee using these mechanisms when installing å plug. He also stated neither a brace nor block was provided with the plugs supplied by United Rentals. Ruano was shown the interview questionnaire used by Noble during his investigation and he agreed that his signature was affixed thereto. (Exhibit 11).

On cross-examination, Ruano testified that Exxon was present at the jobsite prior to the installation of the plug. He was present during the hot work permit inspection conducted by Exxon on February 7, 2008 at approximately 2:00pm which included going over the work to be performed and taking readings of the atmospheric gas (LEL and oxygen) in the pipeline. Exxon pulled on the pipe plug as part of the inspection and he did too after installation was complete. He stated the upstream end of the 14" pipe to be modified had a slip blind flange installed for the purpose of sealing it off. To his knowledge there was nothing in the line when he put the pipe plug in; the pipe had been flushed out. The plug had been in place approximately 45 minutes prior to the welder beginning his work on the flange and pipe.

On re-direct examination, Ruano acknowledged his initials on Exhibit 8 as well as his writing entered on Exhibit 10, pages 1 and 2 up to where he wrote "Flush 14" Line. He stated the other crane operator,

Nathan Romero (Romero), entered the information listed in the last 2 boxes on page 2.

Ruben Berumen (Berumen), Field Superintendent, was called to testify by the Division. Berumen has held his present position for four years and his duties include overseeing and coordinating the work to be done at the job site. He testified that training is hands-on or "on the job" and in this particular instance it was done by Romero. When asked about Exhibit 4, he stated he had not seen the installation instructions before the accident. To his knowledge the on the job training did not involve making use of the installation instructions. He has never seen a brace or block installed in connection with the pipe plug. Looking at Exhibits 3-4 and 3-5, Berumen described the process required to clean out the interior of a pipe (prior to installing the plug) which contains sand ("called stuff or muck") that builds up in the line.

Berumen learned from the injured employee's family that McDonald suffered facial injury, broken teeth and a concussion. McDonald spent approximately 2 weeks in the hospital and he visited the employee at least 15 times either in the hospital (Kern Medical Center) or at the rehabilitation facility.

On cross-examination, Berumen stated he was not present at the worksite on the date of the accident. He testified that Exxon Mobil's workers are present at the work site whenever Employer's employees work. He has worked at the worksite location for almost eight years during which time between 60 and 100 plugs have been installed. Prior to becoming a Superintendent for Employer he worked at the same job site with the company that had the previous contract. All installers or crane operators are experienced. During his entire time working at the worksite, he has never seen a brace or block used with regards to installation of the plug. Berumen stated it was hard to identify the sand or sediment depicted inside the pipe in Exhibits 3-4 and 3-5. He stated that the purpose of cleaning out the pipe is to ensure that no elements are present during the flushing operations and to ensure there is a tight fit for the plug.

Berumen testified that the end of the pipe not being worked on by the welder was closed off prior to the accident. The purpose of closing it is to ensure that nothing got by the line that had to be flushed with water. Berumen stated that Employer is not sure as to what caused the plug to dislodge and strike the welder. The welder's helper, Chris Goodwin, was located on the work platform when the accident occurred but he could not explain to Berumen what caused the plug to dislodge.

Findings and Reasons for Decision

The violation was established by a preponderance of the evidence. The Division established that Employer did not train and instruct its employees before having them install the pneumatic plug. However, the Division did not establish that the lack of training was the cause of the accident. The classification is reduced to General and the proposed penalty of $18,000 is found unreasonable and is not assessed.

The Division cited Employer for violation of section 3203(a)(7)(D) which states, in relevant part, as:

> Effective July 1, 1991, every employer shall establish, implement and maintain an effective Injury and Illness Prevention Program. The Program shall at a minimum provide training and instruction.
>
> (D) Whenever new substances, processes, procedures or equipment are introduced to the workplace and represent a new hazard.

The Division's citation states the employee "had no experience in the installation of large inflatable pipe plugs prior to February 7, 2007 (amended to 2008). The employer did not implement their Injury and Illness Prevention Program Training Procedures which requires job specific training for tasks to be performed to protect employees from actual or anticipated hazards. Nor did the employer provide the Crane Operator with the rental company/manufacturer's written instruction for the proper installation of the inflatable pipe plug."

Ruano testified that he had received on-the-job training regarding the installation of plugs and observed others before he installed his first one. He also indicated that although he had installed between 10 and 14 plugs in the past they were all smaller than the one at issue measuring 14 inches. When asked about the instructions that accompany the plugs from United Rental, Ruano stated that he had seen the instructions in the packaging attached to the plugs, but he could not state with certainty that he had ever read them. He also testified that he had never been instructed on the use of a brace or block for the plugs and stated neither was provided with the plugs that came from United Rental.

The Board stated in *Siskiyou Forest Products,* Decision After Reconsideration, Cal/OSHA App. 01-1418 (Mar. 17, 2003), the word "training" is not defined in the safety orders. Under those circumstances, it is to be construed "... according to the context and the approved usage of the language ...." (See Civil Code section 13, California Drive-In Restaurant Ass'n. v. Clark (1943) 22 Cal.2d 287, and *Sierra Production Service, Inc.*, Cal/OSHA App. 84-1227, Decision After Reconsideration (Aug. 13, 1987).) The purpose of section 3203(a)(7) is to provide employees with the knowledge and ability to recognize, understand and avoid the hazards they may be exposed to by a new work assignment through "training and instruction." The generally accepted and approved meaning of the word "training", when used to describe the process of providing employees with that knowledge and ability in this context is "to instruct so as to make proficient or qualified." (Webster's New World Dictionary, Third College Edition (1989), p.1418.)

The evidence shows the crane operator, Ruano, was not familiar with the pneumatic pipe plug instructions drafted by United Rentals and attached to the plug. Number 5 of the United Rentals Safety Instructions state "blocking/bracing must be used to prevent the movement or complete dislodging of pipe plugs. This blocking or bracing should be designed to contain a dislodged plug and all materials behind the plug should the plug fail.....- **ALWAYS** block the plug to prevent dislodging." It is evident that Ruano was not trained on the instructions provided with the pneumatic plugs. He testified that he was not familiar with them, nor had his Employer trained him on using a brace or block when installing the plugs. Employer's Injury & Illness Prevention Program (IIPP - section VII. pages 11 -13 of 23) "Job or Competency Specific Training" states "this training is focused on developing a specific competency related to a task or to be performed or appropriately protect themselves from actual or anticipated hazards that may be encountered." The list of 23 courses outlined in the IIPP is silent on the issue of training for installation of plugs and the use of blocks or braces to prevent dislodging.

Although Ruano testified that he had installed plugs on prior occasions, he was not familiar with the written United Rentals instructions, nor had they been used in any training provided to him. The Division cited Employer with violating subsection (D) which states training and instruction is required "whenever new substances, processes, procedures or equipment are introduced to the workplace and represent a new hazard". It asserted that Ruano had not installed a pipe plug of this size and thus it was a new process representing a new hazard. Ruano's testimony supports this theory in that he stated all the pipe plugs installed by him in the past were smaller. The Witness Questionnaire memorializing the interview conducted by Noble, indicates this was the first time Ruano had installed that large of a plug (10"-14").

The Questionnaire states Ruano had installed plugs periodically between 2" and 6" and that he had started this job at the Diatomite York Scrubber piping operation the Tuesday prior to the accident. Ruano stated during the questioning that no written installation instructions had been provided.

Ruano also informed Noble that the plug was inflated to a pressure between 20 and 25 PSI using a gauge. [5] The Lansas manufacturer's sheet (Exhibit 6) indicates that for the plug part at issue (#051-1016) the required inflation pressure is 25 PSI, for a 10"-16" pipe size as was the case here.[6] Ruano testified that he had not been presented with the manufacturer's recommendations prior to installing the plug. Furthermore, the United Rentals instructions state inflating plugs to the required pressure is critical to preventing dislodging (due to under-inflation) or plug rupture (due to over-inflation). Never use a pneumatic plug without knowing the proper inflation pressure and back-test pressure." Ruano only testified to having received on the job training regarding plug installation, he stated his training did not include review of these instructions, thus it is inferred he was not made aware of the differing pressure requirements, just as he was not made aware of the need to block the plug as instructed by United Rentals.

Berumen, Field Superintendent, testified that he had never seen the plug installation instructions used when training an employee nor was he familiar with the utilization of a brace or block for placement of the plug. Both employees only testified to having knowledge about the necessity to clean the pipe of sand or sediment build up prior to installing or inserting the pipe plug. The evidence shows Employer had not provided the instructions to Ruano for review or trained him using the information contained in the written instructions which accompanied the plugs obtained from United Rental.

Employer asserts that it trained Ruano on all identifiable or recognized hazards either as part of its hands-on training or during when it reviewed the issues outlined in the Last Minute Risk Assessment Checklist (Exhibit 8) wherein Ruano testified to completing prior to starting the job for the day. However, the record does not support this contention. Ruano testified that prior to the accident; he had never installed a plug larger than 2"-6". He had not read the installation instructions supplied with the 14" plug by United Rentals. He was not aware of the need to use a brace or block as a barrier in preventing the plug from dislodging. The testimony of Berumen, Employer's Field Superintendent in charge of overseeing and coordinating the work supports Ruano's testimony. Berumen had not

[5] Employer's Level III Incident Investigation Report (Exhibit 5) indicates at 13:45 hours "the plug was inflated via a portable air tank to the manufacturer's recommended 25 pounds per square inch (psi).
[6] The Employer's Investigation Report indicates the pipe at issue here had a 14" diameter.

even seen the installation instructions prior to the accident. Berumen did testify that employees were required to attend safety meetings and all installers are experienced. However, general instructions of this nature are not a substitute for specific instructions on hazards unique to an employee's job assignment. *Sturgeon & Son, Inc.*, Cal/OSHA App. 91-1025, Decision After Reconsideration (Jul. 19, 1994), citing *Ford Wholesale Co., Inc.*, Cal/OSHA App. 82-968, Decision After Reconsideration (May 31, 1984); *Semans Moulding Company, Inc.*, Cal/OSHA 82-819, Decision After Reconsideration (Dec. 17, 2985); *Tri/Valley No. 7,* Cal/OSHA App. 82-1029, Decision After Reconsideration (Dec. 18, 1985).)

Although Employer provided its employees with hands-on training, the IIPP (Exhibit 7), Risk Assessment Checklist (Exhibit 8) and Job Safety Analysis (Exhibit 10), neither the training nor any of these documents contained specific instructions on the use of a block or brace when installing a pneumatic plug or identified the hazards associated with installing a plug without using these barrier mechanisms. The undersigned therefore finds that Employer failed to provide training and instruction to Ruano with respect to the 14" pneumatic plug being installed. The Division established the violation alleged in Citation 2.

Classification

Employer stipulated to the calculations made by the Division in accordance with the policies and procedures, however it did not stipulate to the Classification. However, the Division's burden is to prove each element of a violation, and the applicability of the safety order, by a preponderance of the evidence.[7] For a serious violation, the Division must prove that there was a substantial probability that the violation could result in serious physical harm or death.[8] "Substantial probability" refers not to the probability that an accident or exposure will occur as a result of the violation, but rather to the probability that death or serious physical harm will result assuming an accident or exposure occurs as a result of the violation.[9] The evidence must, at a minimum, show the types of injuries that would more likely than not result from the violative condition.[10] A serious violation shall not be deemed to exist, however, if the employer can demonstrate that it did not, and could not with the exercise of reasonable diligence, know of the presence of the violation.[11]

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[7] See *Howard J. White, Inc.*, Cal/OSHA App 78-741, DAR (Jun. 16, 1983); and *Cambro Manufacturing Co.*, Cal/OSHA App. 84-923, DAR Dec.31, 1986). "DAR" in this Decision After Reconsideration refers to Appeals Board Decisions After Reconsideration.

[8] Labor Code Section 6432(a).

[9] *Id* section 6432(b).

[10] *Capital Building Maintenance Services, Inc.*, Cal/OSHA App. 97-680, DAR (Aug. 20, 2001), relying on *Findly Chemical Disposal, Inc.*, Cal/OSHA App. 91-431, DAR (May 7. 1992).

[11] Labor Code Section 6432(c).

The occurrence of a serious injury in a particular case is insufficient, by itself, to establish the "substantial probability" component of the serious classification. Furthermore, the occurrence of a serious injury in one particular instance does not prove that "there is a substantial probability that death or serious physical harm could result from [the specific] violation." In *National Cement Co.*, Cal/OSHA App. 91-310, Decision After Reconsideration (Mar. 10, 1993), the Board stated:

In *Tenneco West, Inc.*, Cal/OSHA App. 79-535, Decision After Reconsideration (Jan. 24, 1985), the Board upheld the serious classification of a section 3203(a) violation because the employer knew of the hazard and its failure to instruct led to the employee's exposure to serious physical harm or death. The Board stated: The Division must focus its proof upon the probable consequences of an accident related to the failure to instruct about a specific hazard. If this hazard is so grave that it threatens the employee with death or serious injury as a substantial probability, and the employer knew, or with the exercise of reasonable diligence, could have known of the existence of the hazard in the workplace, the failure to train the employee concerning such hazard is properly classified as a serious violation." (Id. at p. 3.)

Here, the Division focused its proof upon the specific hazard of not providing training and instruction while utilizing the installation instructions provided by the rental company that supplied the pneumatic plug. The failure to train the crane operator about proper installation of the 14" plug (including proper inflation psi and installation with a block or brace), played a role in the dislodging of the plug, as an identified hazard in the written installation instructions. Installation of the plug was not addressed in Employer's IIPP, Employer had knowledge of the danger of dislodgement as identified in its JSA (install plug – hazard indicated "blowouts").

In *Dennis J. Amoroso Construction Co., Inc.*, Cal/OSHA App. 98-4256, DAR (Dec. 20, 2001) "substantial probability" was supported by evidence of the types of injuries that could occur; in *Contra Costa Electric, Inc.*, Cal/OSHA App. 90-470, DAR (May 8, 1991) there was testimony based upon past history of such accidents to support "substantial probability." In the instant case there was *no evidence* presented by the Division to address the "substantial probability" requirement for classifying the violation as serious accident-related. Noble stated that given the weight of the plug and the bolts protruding from the end of the plug, it is more likely than not that serious injury or hospitalization would result from dislodging of a pneumatic plug.

Ordinarily, the party with the burden of proof offers evidence of "substantial probability" through testimony of a witness who states how

many inspections of this kind have been conducted and the percentage of cases that result in serious injury. The Appeals Board has held that to support a serious classification, an opinion about the substantial probability of serious physical harm or death must be based upon a valid evidentiary foundation, such as expertise on the subject, reasonably specific evidence, an experience-based rationale, or generally accepted empirical evidence. (See *Wright & Associates, Inc.,* Cal/OSHA App. 9503649, Decision After Reconsideration (Nov. 11, 1999).) No evidence was introduced as to whether Noble had any specific knowledge, skill, experience, training or education regarding the injuries caused by the violative condition, lack of training and use of written instructions regarding the installation of the plug.

The evidence must, at a minimum, show the types of injuries that would more likely than not result from the condition which forms the basis of the violation. (See *Findly Chemical Disposal, Inc.*, Cal/OSHA App. 91-431, Decision After Reconsideration (May 7, 1992.).) Otherwise, the Board is left only to "speculate" regarding the likelihood of a serious injury from a particular hazard. (See e.g., *Ray Products, Inc.*, Cal/OSHA App. 99-3169, Decision After Reconsideration (Aug. 23, 2002).) Hence, the Division must prove the probable direct results of (the violative condition) not merely the possible effects. (See *Quang Trinh*, Cal/OSHA App. 9301697, Decision After Reconsideration (June 25, 1998).) Noble's testimony was only relevant to the injury directly caused by the dislodged plug. Noble only stated that he had investigated four accidents specific to pressure build up. Although the Division proved the existence of the violation (Employer's failure to train and instruct on the use of a block or brace) it was unable to show both, the failure to train and instruct on using a brace or block and the amount of pressure required to rupture or dislodge a plug was sufficiently present to cause serious physical harm.

The burden is on the Division to prove that there was a substantial probability of serious physical harm resulting from the violative condition assuming an accident occurs as a result of the violation. This burden is not met by a mere recitation of the requirements of what constitutes a serious violation. This ALJ cannot, without more, make a finding that a serious violation existed at the time Employer failed to adequately train and instruct the crane operator. (*Architectural Glass and Aluminum Co., Inc.*, Cal/OSHA App. 01-5031, Decision After Reconsideration (March 22, 2004).)

The Division asserted at one point that the failure to provide a block or brace to prevent movement or complete dislodging of the pipe plug caused the injury; however the Division also asserted that the failure to have enough ventilation (see below Summary of Evidence – Citation 3), caused the plug to dislodge. The Division has the burden of proof and would have to have shown not only that a defective or inadequately installed plug caused the accident, but that the amount of

pressure required to rupture or dislodge the plug was also sufficient to cause serious physical harm. Furthermore, there was not sufficient evidence put forth by the Division that there was some pressure in the line or some force within it to exert pressure on the plug. Both the lack of a barrier and sufficient pressure could be "causes". Employer and Exxon never determined exactly what caused the plug to expel. The Division did not clearly determine or assert that it knows what caused the plug to dislodge or fail. Thus it is not clear that even with a block or brace the plug would not have dislodged due to the pressure or air in the pipe. The Division did not meet its burden with regards to the accident-related characterization.

The Division has not proven that the Serious classification was appropriate. Therefore, the violation must be viewed as a General Violation, and the penalty re-calculated accordingly. The appropriate penalty classification is set out in the section below.

The Appropriate Penalty

The violation is classified as General as determined above. Employer stipulated that the Division calculated the proposed penalties in accordance with the regulations and its policies. The severity of the violation will be rated as high, due to injuries sustained and the medical treatment received by the injured employee, in accordance with section 335(a)(1)(A)(ii), meaning that the starting point for the penalty calculation is $2,000. The Division did not rate extent and likelihood for Citation 2 because it was issued as an accident-related violation.

Extent shall be rated as high, because the evidence shows that on the 10 to 14 times the plug had been installed, Employer had not trained or instructed this employee using the instructions provided by United Rentals. Thus, 25% shall be added to the base penalty. Likelihood will be rated as low[12]. There was only one employee exposed to the hazard

[12] The requirements of Extent are outlined in § 335(a)(2):

> Extent shall be based upon the degree to which a safety order is violated. It is related to the ratio of the number of violations of a certain order to the number of possibilities for a violation on the premises or site.

And, the requirements of Likelihood are found in § 335(a)(3) which state in relevant part:

> Likelihood is the probability that injury, illness or disease will occur as a result of the violation. Thus, Likelihood is based on (i) the number of employees exposed to the hazard created by the violation, and (ii) the extent to which the violation has in the past resulted in injury, illness or disease to the employees of the firm and/or industry in general, as shown by experience, available statistics or records.

(McDonald) and there was no evidence put forth demonstrating the violation had resulted in injury in the past. Thereby 25% shall be subtracted from the base penalty.

On the Proposed Penalty Worksheet, the Division rated Employer's Good Faith as fair (15%), History as Good (10%) and Size as zero.

Applying the aforementioned adjustment factors of 25 percent reduces the gravity base penalty to $1500. Including a 50 percent abatement credit, the final adjusted penalty deemed reasonable and to be assessed is $750 for Citation 2, Item 1. [§ 336(e)]

Docket 08-R6D4-1456

Citation 3, §3329(d), Serious

Summary of Evidence

Noble determined from his interviews with employees at the worksite that just prior to the pipe plug discharging, they heard pressure emitting from the plug. The welder's helper who was on the end where McDonald was working, stated he heard and felt a big rush of air just as it expelled from the pipe. Noble believes this situation would have been prevented by larger ventilation. The only pressure release vent in the entire pipeline was 2" and 80 feet from the end of the pipeline where the flange was being worked on. It was insufficient.

On cross-examination Noble stated the employee was not opening the pressurized system. He believes that when McDonald was attempting to install the slip-on flange, the system had been closed back up by virtue of installing the inflatable plug, thus allowing pressure build-up. He admitted the pipe had already been dismantled, however Employer did not ensure that the internal pressure was relieved while they were still in a dismantled state "the line was still open although plugged back up". Exhibit 3-2 depicts the dismantled state of the pipeline. The job was not finished at the time, the employee was still welding with the purpose of attaching or re-attaching the two pipes (Exhibit 3-1).

Findings and Reasons for Decision

The violation was not established by a preponderance of the evidence. The proposed penalty of $6,750 is found unreasonable and is not assessed.

The Division cited Employer for violation of section 3329(d) which states, in relevant part:

> When dismantling or opening closed pressurized or gravity fed systems internal pressure shall be relieved of other methods utilized to prevent sudden release of pressure or spraying of liquid.

The dictionary definition of dismantle is to take apart, disassemble or tear down. Evidence shows that at the time the pipe plug dislodged the welder was tack welding or installing a slip-on flange at the open end of the 14" pipe. Pictures taken by the Division indicate the pipe had already been dismantled as this activity is conducted prior to the welding and subsequent to the installation of the plug. There is no evidence of ongoing dismantling or opening of a closed pressurized system. The line had already been flushed and the LEL meter reading was conducted by Exxon Mobile according to Employer's incident report (Exhibit 5) as well as Ruano's testimony, prior to the installation of the pipe plug. Thus, all dismantling and line opening activities had ceased by the time McDonald was instructed to install the slip-on flange and therefore the cited safety order is not applicable to these facts. The citation is dismissed.

Decision

It is hereby ordered that the citations are established, modified, or withdrawn as indicated above and set forth in the attached Summary Table.

It is further ordered that the penalties indicated above and set forth in the attached Summary Table be assessed.

DATED: September 25, 2008

Ursula L. Clemons

URSULA L. CLEMONS
Administrative Law Judge

ULC:ao

AMENDED SUMMARY TABLE
DECISION

In the Matter of the Appeal of:

IRWIN INDUSTRIES, INC.
DOCKETS 08-R4D4-1454 through 1456

Abbreviation Key:
Reg=Regulatory
G=General W=Willful
S=Serious R=Repeat
Er=Employer
DOSH=Division

IMIS No. 125915363

DOCKET	CITATION	ITEM	SECTION	TYPE	MODIFICATION OR WITHDRAWAL	AFFIRMED	VACATED	PENALTY PROPOSED BY DOSH IN CITATION	PENALTY PROPOSED BY DOSH AT HEARING	**FINAL PENALTY ASSESSED BY BOARD**
08-R4D4-1454	1	1	3400(b)	G	ALJ upheld citation.	X		$ 560	$ 560	**$ 560**
08-R4D4-1455	2	1	3203(a)(7)(D)	S	ALJ upheld citation in part and dismissed in part, ***reclassifying the citation to G and reducing penalty.***	X		18,000	18,000	**750**
08-R4D4-1456	3	1	3329(d)	S	ALJ dismissed citation.		X	6,750	6,750	**0**
					Sub-totals			$ 25,310	$ 25,310	**$ 1,310**

Total Amount Due* **$ 1,310**

(INCLUDES APPEALED CITATIONS ONLY)

*You will owe more than this amount if you did not appeal one or more citations or items containing penalties.
Please call (415) 703-4291 if you have any questions.

NOTE: Payment of final penalty amount should be made to:
Accounting Office (OSH)
Department of Industrial Relations
P.O. Box 420603
San Francisco, CA 94142

POS: 09/25/2008
ALJ: ULC/ao

DECLARATION OF SERVICE BY MAIL

I, the undersigned, declare as follows:

I am a citizen of the United States, over the age of 18 years and not a party to the within action; my place of employment and business address is Occupational Safety and Health Appeals Board, 100 North Barranca Street, Suite 410, West Covina, California, 91791.

On July 7, 2011, I served the attached **Erratum** by placing a true copy thereof in an envelope addressed to the persons named below at the address set out immediately below each respective name, and by sealing and depositing said envelope in the United States Mail at West Covina, California, with first-class postage thereon fully prepaid. There is delivery service by United States Mail at each of the places so addressed, or there is regular communication by mail between the place of mailing and each of the places so addressed:

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DOSH – Legal Unit
320 W. Fourth Street, Suite 400
Los Angeles, CA 90013

I declare under penalty of perjury that the foregoing is true and correct.

Executed on July 7, 2011, at West Covina, California.

Cheryl Brantley
Declarant

/ao